



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARK R DALTON
PO BOX 268969
OKLAHOMA CITY OK 73126

Respondent Name

Texas Mutual Insurance Co

Carrier's Austin Representative

Box Number 54

MFDR Tracking Number

M4-12-3228-01

MFDR Date Received

June 15, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted with DWC060.

Amount in Dispute: \$200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual has no record of a request for reconsideration from the requestor nor has the requestor shown through the DWC-60 packet that it submitted such request. For this reason the requestor has not exhausted its administrative remedies prior to requesting medical fee dispute."

Response Submitted by:

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 1, 2012	Professional Services	\$200.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.250 sets out guidelines for reconsideration of payment of medical bills.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC – 150 PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE
 - 890 – DENIED PER AMA CPT CODE DESCRIPTION FOR LEVEL OF SERVICE AND/OR NATURE OF PRESENTING PROBLEMS.

Issues

1. Did the requestor submit timely reconsideration prior to requesting Medical Fee Dispute Resolution?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §133.250(h) states in pertinent part, "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)." Review of the submitted documentation found no record of reconsideration.
2. Requestor did not utilize reconsideration process prior to requesting MFDR therefore; disputed services are not eligible for review.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	December , 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.